

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2011

FORM APPROVED

OMB NO. 0938-0391

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|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/10/2011 | |
| NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN46815 | | | |
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| F0000 | <p>This visit was for the Investigation of Complaint IN00099184 and IN00099274.</p> <p>Complaint IN00099184 and IN00099274 Substantiated, Federal/State deficiencies related to the allegations are cited at F201, F250, F279, F285, and F406.</p> <p>Survey dates: November 9, 10, 2011</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Sheryl Roth RN TC Sue Brooker RD Rick Blain RN (November 10, 2011)</p> <p>Census bed type: SNF/NF: 139 Total: 139</p> <p>Census payor type: Medicare: 11 Medicaid: 99 Other: 29 Total: 139</p> | | | F0000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F0201 SS=D | <p>Sample: 3</p> <p>These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/14/11 Cathy Emswiller RN</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> | | | | | | |

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| | <p>Based on record review and interview, the facility failed to assess, monitor, and document behaviors for 1 of 3 residents reviewed for behaviors, and failed to ensure the physician or facility documented in the clinical record justification as to why the facility could not meet the needs of the resident in the facility or that the resident was a danger to others. [Resident #C]</p> <p>Findings include;</p> <p>Resident #C's record was reviewed on 11/9/11 at 10:00 a.m. The record indicated Resident #C's diagnoses included, but were not limited to, fractured femur (hip), cerebrovascular accident (stroke), chronic obstructive pulmonary disease, legal blindness, and schizoid personality.</p> <p>A "Pre-Admission Assessment Summary," dated 1/24/11, indicated Resident #C did not have any behaviors or antipsychotic/antianxiety/antidepressant medications and was going to LTC for short term rehab.</p> <p>The "Physician Certification for Long-Term Care Services," dated 1/25/11, indicated Resident #C was being admitted to the facility after a fractured hip repair. The note further indicated the resident</p> | | F0201 | <p>I. Resident #C no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>II. All residents with behaviors have the potential to be affected, therefore, this plan of correction applies to all of those residents. The medical records of these residents have been reviewed to determine if behaviors have been appropriately assessed, monitored, and documented with any identified concerns corrected.</p> <p>At this time there are no residents whose needs cannot be met in the facility. All resident records have been reviewed in an effort to ensure all recommended psychiatric follow-up has been done, and to ensure any residents requiring referral to PASRR for Level II completion have been referred accordingly. The care plans of all residents currently receiving</p> | | 12/10/2011 | |

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| | <p>was unable to care for self independently at home, required 24-hour care, assist and supervision due to diagnosis.</p> <p>Resident Progress Notes," dated 1/26/11 at 8:00 p.m., indicated resident had some confusion, was yelling at staff to leave him alone and was non-compliant with personal alarm.</p> <p>"Resident Progress Notes," dated, 1/26/11 at 1:00 p.m., indicated Resident #C was easily agitated at staff and yells out and slaps at staff during care.</p> <p>Admission care plan for inappropriate behaviors, dated 1/27/11, indicated resident displays inappropriate behaviors as evident by yelling at staff, refusing care, and non-compliant with PA. There was nothing in the care plan that the resident was abusive towards residents.</p> <p>The nursing assistant care record for February 2011, indicated Resident #C had three behaviors 2/1, 2, 3, 4, 7, 8, 9, 11, and two behaviors on 2/12. There were no behavior sheets or documentation in the nurse's notes for 2/1, 2, 3, 4, to indicate what the behaviors were or behavior summaries from social services. The behavior for 2/7 was listed in the nursing notes which indicated the resident removed his personal alarm and hid the</p> | | | | <p>psychotropic medications have been reviewed to ensure the same are addressed.</p> <p>The care plans of any resident who have voiced a preference for male versus female, or vice versa, caregivers have been reviewed to ensure the same is addressed.</p> <p>III. Nursing center staff have received in-service education relative to behavior management process, including but not limited to behavior assessment, monitoring, and documentation. Social Service staff, Business Office Manager, and Admissions Coordinator have been in-serviced on PASRR process and requirements, including but not limited to the need for a Level II referral in the event of a behavioral condition change. Social Service staff and Licensed Nursing staff have received in-service education relative to the</p> | | |

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| | <p>parts to it. The nurse's note for 7/9/11 indicated resident had yelled at the staff all shift. Again, there were no behavior sheets or further details to indicate the conditions occurring during the behaviors nor that any behaviors included other residents.</p> <p>March nursing assistant care record had one behavior on the 9th (AM). PM shift had behaviors x2 on 3/1, 2, 3, 4, 5, 6, 7, 8, and one on the 9th and two on the 10th. There were no behaviors sheets or monthly monitoring by social services located in the chart for these behaviors. No behaviors were noted in the nursing notes for the month of March.</p> <p>"Resident Progress Notes," indicated on 4/13/11, resident displayed behaviors toward CNA per therapy. Resident agitated and threw water pitcher at CNA.</p> <p>Inappropriate behavior care plan, dated 1/27/11, had an updated behavior 4/14/11 but no new interventions.</p> <p>April monthly behavior monitoring flowsheet had verbal aggression on 4/19.</p> <p>May nursing assistant care record had 3 behaviors on the 2nd. May monthly behavior monitoring flowsheet had inappropriate gestures on 5/7 and 5/8;</p> | | | | <p>care plan process, including but not limited to inclusion of psychotropic medication use, compliance with recommended psychiatric follow-up, and any care preferences voiced by residents.</p> <p>A performance improvement tool has been developed to monitor compliance with behavior management process, as well as PASRR paperwork and required level II.</p> <p>A performance improvement tool has been developed to monitor compliance with addressing of psychotropic medications and resident care preferences on care plans. Executive Director, or designee, and Social Service staff, or designee, shall be responsible for completion of these PI tools daily, on scheduled days of work, for 30 days. Any identified concerns will be promptly addressed with responsible individual(s).</p> <p>IV. Social Service staff will review findings weekly and</p> | | |

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| | <p>verbal aggression on 2nd and 8th. The monthly behavior summary/psychoactive GDR dated June which reviewed May behaviors had 2 incidents of verbal aggression and 1 of inappropriate gestures.</p> <p>"Resident Progress Notes," dated 6/2/11 at 6:30 p.m., indicated resident observed shoving a glass of milk towards a resident at his table because resident was tapping his cup at the table.</p> <p>"Resident Progress Notes," dated 6/2/11 at 7:30 p.m., resident witnessed walking past a peer and purposefully kicking peer. Resident placed on 1:1.</p> <p>A new care plan listed resident kicking another resident 6/6/11. Talked about 15 minute checks.</p> <p>A "Resident Monitoring Tool," dated 6/8/11, indicated the resident threw a chair at a CNA and that the resident was put on 15 minute checks.</p> <p>A telephone order dated 6/10/11, indicated to send Resident #C to local hospital for psychiatric care.</p> <p>History and Physical from a local hospital, dated 6/10/11, indicated "...resident...of an extended care facility,</p> | | | <p>report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>Completion Date: 12.10.11</p> | | | |

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| | <p>who recently increasingly agitated and combative...this patient has been an extended care facility resident since he had a fractured hip in February 2011...."</p> <p>A "Resident Transfer Form," dated 6/10/11, indicated Resident #C was being transferred to the psychiatric unit at a local hospital due to behavioral disturbance. The form was incomplete under several categories.</p> <p>Progress notes from local hospital, dated 6/15/11, indicated resident "remains schizoid...makes it clear though that he prefers male company to female...keeps to himself and continues to isolate with his headphones or by remaining in his room...."</p> <p>An "External Transfer Report," dated 6/17/11 from a local hospital, indicated Resident #C had been hospitalized from 6/10/11 through 6/17/11 and was being transferred back to the facility. The report indicated the resident was confused at times and was to follow up with psych care in 4-6 weeks. No follow up was done. A level II was not done.</p> <p>Hospital discharge notes indicated the resident was returning to the facility with a new order for abilify 3mg every bedtime.</p> | | | | | | |

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| | <p>A "Nursing Assessment/Full," dated 6/17/11, indicated Resident #C was admitted to the facility on 6/17/11 and indicated a diagnosis of schizoid disorder. The form did not list that the resident was on the antipsychotic medication abilify. It again listed the resident as a non-smoker, that the resident was occasionally confused, and had no mental retardation or dementia.</p> <p>A "Doctor's Progress Notes," dated 6/20/11, indicated Resident #C was sent out to a local psych unit due to increased combativeness, agitation with mental health history. Indicated the resident was on Ability (antipsychotic medication) for schizoid disorder.</p> <p>The "Medication Regimen Review," dated 6/29/11, and signed by the pharmacist, indicated the resident returned from the hospital with an order for Abilify (antipsychotic) for schizoid disorder.</p> <p>June nursing assistant care records for AM listed behaviors x 2 on 6/1 and only 1 behavior on 6/2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 20. The June monthly behavior monitoring flowsheet had verbal aggression on the 19th and 20th; inappropriate gestures on 6/5 and throwing objects on 6/2. The July</p> | | | | | | |

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| | <p>monthly behavior summary/psychoactive GDR review listed no behaviors for June.</p> <p>"Resident Progress Notes," dated 7/9/11, indicated resident confused and yelling at staff all shift.</p> <p>An "Intra-facility Transfer," dated 7/12/11, indicated Resident #C was moved from Room [room number documented] to Room [room number documented] for bed management.</p> <p>"Resident Progress Notes," dated 7/18/11 at 9:30 a.m., roommate reported writer turning off the air in their room and what the resident had said to the CNA.</p> <p>"Resident Progress Notes," dated 7/24/11 at 7:50 a.m., CNA instructed resident to change his clothes and resident stated "Go yourself."</p> <p>"Resident Progress Notes," dated 7/25/11 at 11:30 p.m., resident became upset in MDR this evening because a resident accidentally hit his foot with her w/c pedal. Resident threw silverware on the ground and left MDR.</p> <p>July nursing assistant care record had no behaviors marked. The July monthly behavior monitoring flowsheet listed verbal aggression on 7/18 and 7/25.</p> | | | | | | |

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| | <p>"Resident Progress Notes," 7:30 a.m., patient cursed at CNA for asking him to change out of dirty clothes.</p> <p>"Determining Cause of Disruptive Behavior," dated 8/18/11, indicated physically aggressive behavior. It indicated the resident was upset with the housekeeper who was temporarily moving his belongings from room to lounge while floor being torn up/replaced. The report indicated Resident #C hit the housekeeper on the arm. Possible trigger "...did not understand fully that his things were being temporarily moved, thought things were being taken...." See nurse's notes for further details.</p> <p>August nursing assistant care records have no behaviors. Monthly behavior monitoring flowsheet for August had one inappropriate gesture on the 30th, and verbal aggression on the 3rd, 6th, 9th, 12th.</p> <p>A care plan for risk for adverse effects related to use of psychotropic medication (abilify), dated 9/8/11 however abilify was started in June.</p> <p>A care plan for self care deficit (ADL), dated 9/8/11, did not list the resident prefers males, it did not list that resident</p> | | | | | | |

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| | <p>had been refusing showers and changing clothes or other behaviors.</p> <p>September nursing assistant care record - 2 behaviors on night shift 9/1. There was no September monthly behavior monitoring flowsheet.</p> <p>A "Resident Progress Notes," dated 10/3/11 at 4:50 p.m., indicated there was a report from a visitor that her 3 year old son was standing on the scale in the B-wing lounge when Resident #C came in and pushed the child down and swore at the child. A note for 5:10 p.m., indicated the physician was notified and a new order was received to send the resident to a local hospital for evaluation and treatment. The last note was timed 7:15 p.m. and indicated a call was received from the resident's friend who was notified of the resident being sent to the emergency room. There were no other notes after this entry.</p> <p>A "Resident Transfer Form," dated 10/3/11, indicated Resident #C was transferred to a local acute hospital emergency room. Diagnoses included: schizoid personality, hemiplegia, cerebrovascular accident (stroke), anemia and congestive heart failure. The reason for transfer listed increased agitation with the resident pushing a 3 y/o child down.</p> | | | | | | |

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| | <p>The additional pertinent information indicated the resident pushed a visitor's 3 year old child who was on the scale. The resident told the child to "get his little ... off there. The note further indicated the resident had impulsive behavior, some problems with temper and anger at times.</p> <p>October nursing assistant care records had no behaviors marked. October monthly behavior monitoring flowsheet had one incident of physical aggression and anger with others on 10/3.</p> <p>The most recent inservice for behaviors, dated 8/1/11, listed the following: "...some common behaviors...physical aggression...verbal aggression...exit seeking...resisting or refusing care...obsessive behavior...if behaviors are not reported and logged, it is very difficult to maintain them...the social worker must be notified in writing of new behaviors...behaviors must be logged on the behavior logs in the nurses station...."</p> <p>The current policy and procedure for "Resident Exhibiting Challenging Behaviors," dated 6/30/06 was provided by the Director of Nursing on 11/10/11 at 12:00 p.m. The policy listed the following: "...A resident exhibiting behavior symptom is intervened with measures that reduce and/or eliminate</p> | | | | | | |

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| | <p>behavior episodes while protecting the resident and/or others from harm...record the behavior(s) exhibited, interventions tried but unsuccessful, and/or successful interventions used on behavior monitoring log or similar tracking device...update the resident's care plan, as needed...communicate resident behavior symptoms to appropriate disciplines...evaluate resident condition every shift for at least 72-hours or more frequently as determined by the interdisciplinary team...document sequence of events of resident's behavior in resident's medical record...details of the event...staff monitoring, if applicable...document behaviors and interventions on behavior monitoring log or similar tracking device...."</p> <p>An interview was conducted with the Health Facility Administrator (HFA), Director of Nursing (DON) and Social Worker #3 and #4 on 11/10/11 at 12:20 p.m. During the interview, the HFA and DON indicated there was no documentation from the physician that the resident was a danger to others or that he couldn't be admitted back to the facility.</p> <p>An interview was conducted with the Health Facility Administrator (HFA) on 11/10/11 at 1:40 p.m. During the interview, the HFA indicated the decision</p> | | | | | | |

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| F0250 SS=D | <p>to not accept the resident back to the facility was made by the interdisciplinary team.</p> <p>This Federal tag relates to Complaint IN00099184 and IN00099274.</p> <p>3.1-12(a)(4)(A) 3.1-12(a)(4)(C)</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a psychiatric appointment was scheduled and attended; implemented new interventions and care plans for behaviors and preferences for male caregivers, hoarding and fear of belongings being stolen; to providing complete documentation of behaviors and analysis of potential triggers; to notify PASRR of a change in condition and new diagnosis; and to follow-up to the acquisition of a POA or guardian as recommended by psych for 1 of 3 residents reviewed for behaviors and psychiatric diagnosis. [Resident #C]</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on</p> | | F0250 | <p>F 250</p> <p>I. Resident #C no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>II. All residents with behaviors have the potential to be affected, therefore, this plan of correction applies to all of those residents. The medical records of these residents have been reviewed to determine if behaviors have been appropriately assessed,</p> | | 12/10/2011 | |

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| | <p>11/9/11 at 10:00 a.m. The record indicated Resident #C's diagnoses included, but were not limited to, fractured femur (hip), cerebrovascular accident (stroke), chronic obstructive pulmonary disease, legal blindness, and schizoid personality.</p> <p>A "Pre-Admission Assessment Summary," dated 1/24/11, indicated Resident #C did not have any behaviors or antipsychotic/antianxiety/antidepressant medications and was going to LTC for short term rehab.</p> <p>"Resident Progress Notes," dated 1/26/11 at 8:00 p.m., indicated resident had some confusion, was yelling at staff to leave him alone and was non-compliant with personal alarm.</p> <p>"Resident Progress Notes," dated, 1/26/11 at 1:00 p.m., indicated Resident #C was easily agitated at staff and yells out and slaps at staff during care.</p> <p>Admission care plan for inappropriate behaviors, dated 1/27/11, indicated resident displays inappropriate behaviors as evident by yelling at staff, refusing care, and non-compliant with PA. The approaches listed to redirect the resident when inappropriate behaviors occur, remind resident of acceptable behaviors,</p> | | | | <p>monitored, and documented with any identified concerns corrected. All resident records have been reviewed in an effort to ensure all recommended psychiatric follow-up has been done, and to ensure any residents requiring referral to PASRR for Level II completion have been referred accordingly. The care plans of any resident who have voiced a preference for male versus female, or vice versa, caregivers have been reviewed to ensure the same is addressed. The care plans of all residents currently receiving psychotropic medications have been reviewed to ensure the same are addressed.</p> <p>III. Nursing center staff have received in-service education relative to behavior management process, including but not limited to behavior assessment, monitoring, and documentation.</p> | | |

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| | <p>remove resident or other residents from any uncomfortable situations and mental health services as needed. No additional interventions were added.</p> <p>"Resident Progress Notes," dated 1/30/11 at 9:05 p.m., indicated Resident #C takes his nicotine patch off himself. No care plan was noted in the clinical record during review on 11/9/11 at 10:00 a.m. for the removing of nicotine patch by resident.</p> <p>"Resident Progress Notes," dated 2/7/11 at 4:15 p.m., resident removes personal alarm and hides pieces.</p> <p>"Resident Progress Notes," dated 2/20/11 at 7:05 a.m., new order received for discontinuing nicotine patch related to resident ripping the patch off as soon as the nurse puts it on times three.</p> <p>March nursing assistant care record had one behavior on the 9th (AM). PM shift had behaviors x2 on 3/1, 2, 3, 4, 5, 6, 7, 8, and one on the 9th and two on the 10th.</p> <p>Care Plan Conference Summary, dated 3/25/11, indicated friend and resident were in attendance but they did not sign the attendance record. Summary indicated resident prefers doing his own thing, decreased safety awareness, poor</p> | | | <p>Social Service staff, Business Office Manager, and Admissions Coordinator have been in-serviced on PASRR process and requirements, including but not limited to the need for a Level II referral in the event of a behavioral condition change.</p> <p>Social Service staff and Licensed Nursing staff have received in-service education relative to the care plan process, including but not limited to inclusion of psychotropic medication use, compliance with recommended psychiatric follow-up, and any care preferences voiced by residents.</p> <p>A performance improvement tool has been developed to monitor compliance with behavior management process, as well as PASRR paperwork and required level II.</p> <p>A performance improvement tool has been developed to monitor compliance with addressing of psychotropic medications</p> | | | |

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| | <p>safety awareness, impulsive per physical therapy, discharge possibly to assisted living.</p> <p>"Resident Progress Notes," indicated on 4/13/11, resident displayed behaviors toward CNA per Anna in therapy. Resident agitated and threw water pitcher at CNA.</p> <p>Inappropriate behavior care plan, dated 1/27/11, had an updated behavior 4/14/11 but no new interventions.</p> <p>April monthly behavior monitoring flowsheet had verbal aggression on 4/19.</p> <p>May nursing assistant care record had 3 behaviors on the 2nd. May monthly behavior monitoring flowsheet had inappropriate gestures on 5/7 and 5/8; verbal aggression on 2nd and 8th. The monthly behavior summary/psychoactive GDR dated June which reviewed May behaviors had 2 incidents of verbal aggression and 1 of inappropriate gestures.</p> <p>"Resident Progress Notes," dated 6/2/11 at 6:30 p.m., indicated resident observed shoving a glass of milk towards a resident at his table because resident was tapping his cup at the table.</p> | | | | <p>and resident care preferences on care plans. Executive Director, or designee, and Social Service staff, or designee, shall be responsible for completion of these PI tools daily, on scheduled days of work, for 30 days. Any identified concerns will be promptly addressed with responsible individual(s).</p> <p>IV. Social Service staff will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>Completion Date: 12.10.11</p> | | |

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| | <p>"Resident Progress Notes," dated 6/2/11 at 7:30 p.m., resident witnessed walking past a peer and purposefully kicking peer.</p> <p>A new care plan listed resident kicking another resident 6/6/11. The new approaches indicated to notify the Physician or Power of Attorney POA (resident did not have a POA), attempt to find source of conflict, separate residents to ensure safety, and remove resident away from source of agitation.</p> <p>A "Resident Monitoring Tool," dated 6/8/11, indicated the resident threw a chair at a CNA and that the resident was put on 15 minute checks.</p> <p>"Resident Progress Notes," dated 6/8/11 at 4:25 p.m., spoke with resident regarding going to Generations. Resident agreed to go but Generations stated he does not meet the criteria for inpatient admission.</p> <p>History and Physical from a local hospital, dated 6/10/11, indicated "...resident...of an extended care facility, who recently became increasingly agitated and combative...this patient has been an extended care facility resident since he had a fractured hip in February 2011...."</p> <p>"Resident Progress Notes," dated 6/10/11 at 12:25 p.m. Social Worker made</p> | | | | | | |

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| | <p>referral to Generations and faxed paperwork and the 4:00 p.m. note indicated resident transferred to Generations.</p> <p>A "Resident Transfer Form," dated 6/10/11, indicated Resident #C was being transferred to the psychiatric unit at a local hospital due to behavioral disturbance.</p> <p>Progress notes from local hospital, dated 6/15/11, indicated resident "remains schizoid...makes it clear though that he prefers male company to female...keeps to himself and continues to isolate with his headphones or by remaining in his room...."</p> <p>An "External Transfer Report," dated 6/17/11 from a local hospital, indicated Resident #C had been hospitalized from 6/10/11 through 6/17/11 and was being transferred back to the facility. The report indicated the resident was confused at times and was to follow up with psych care in 4-6 weeks. No follow up was done nor was a change of condition reported to Pre-Admission Screening and Resident Review (PASRR) services to have a level II performed which is completed to ensure individuals with serious mental illness who apply to or resident in a nursing facility, and specifies services required in</p> | | | | | | |

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| | <p>order for the placement to be appropriate.</p> <p>A "Nursing Assessment/Full," dated 6/17/11, indicated Resident #C was admitted to the facility on 6/17/11 and indicated a diagnosis of schizoid disorder. The form did not list that the resident was on the antipsychotic medication abilify. It again listed the resident as a non-smoker, that the resident was occasionally confused, and had no mental retardation or dementia.</p> <p>A "Doctor's Progress Notes," dated 6/20/11, indicated Resident #C was sent out to a local psychiatric unit due to increased combativeness, agitation with mental health history. Indicated the resident was on Ability (antipsychotic medication) for schizoid disorder.</p> <p>June nursing assistant care records for AM listed behaviors x 2 on 6/1 and only 1 behavior on 6/2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 20. The June monthly behavior monitoring flowsheet had verbal aggression on the 19th and 20th; inappropriate gestures on 6/5 and throwing objects on 6/2. The July monthly behavior summary/psychoactive GDR review listed no behaviors for June.</p> <p>"Resident Progress Notes," dated 7/9/11, indicated resident confused and yelling at</p> | | | | | | |

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| | <p>staff all shift.</p> <p>"Resident Progress Notes," dated 7/11/11 at 4:00 p.m., writer spoke with friend regarding POA or guardianship being established. Resident friend is an attorney and has agreed to write up paperwork and initiate process soon. There was no further documentation of a follow up to the POA request.</p> <p>An "Intra-facility Transfer," dated 7/12/11, indicated Resident #C was moved from Room [room number documented] to Room [room number documented] for bed management. There was no care plan for adjustment to the facility or to the room change.</p> <p>"Resident Progress Notes," dated 7/18/11 at 9:30 a.m., roommate reported writer turning off the air in their room and what the resident had said to the CNA.</p> <p>"Resident Progress Notes," dated 7/24/11 at 7:50 a.m., CNA instructed resident to change his clothes and resident stated "Go f--- yourself."</p> <p>Resident Progress Notes," dated 7/25/11 at 11:30 p.m., resident became upset in MDR this evening because a resident accidentally hit his food with her w/c pedal. Resident threw silverware on the</p> | | | | | | |

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| | <p>ground and left MDR.</p> <p>July nursing assistant care record had no behaviors marked. The July monthly behavior monitoring flowsheet listed verbal aggression on 7/18 and 7/25.</p> <p>"Resident Progress Notes," 7:30 a.m., patient cursed at CNA for asking him to change out of dirty clothes.</p> <p>"Determining Cause of Disruptive Behavior," dated 8/18/11, indicated physically aggressive behavior. It indicated the resident was upset with the housekeeper who was temporarily moving his belongings from room to lounge while floor being torn up/replaced. The report indicated Resident #C hit the housekeeper on the arm. Possible trigger "...did not understand fully that his things were being temporarily moved, thought things were being taken...." See nurse's notes for further details. There was no care plan for the resident's hoarding or concerns with his belongings being taken.</p> <p>August nursing assistant care records have no behaviors. Monthly behavior monitoring flowsheet for August had one inappropriate gesture on the 30th, and verbal aggression on the 3rd, 6th, 9th, 12th.</p> | | | | | | |

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| | <p>Consultant pharmacist's medication regimen review, dated 8/28/-8/30/11, indicated labs were missing in the chart. A hand written note indicated the resident had refused and the orders were canceled.</p> <p>A care plan for risk for adverse effects related to use of psychotropic medication (abilify), was dated 9/8/11 even though the resident started the medication in June.</p> <p>A care plan for self care deficit (ADL), dated 9/8/11, did not list that the resident preferred males and it did not list that the resident had been refusing showers and changing clothes or other behaviors.</p> <p>September nursing assistant care record - 2 behaviors on night shift 9/1. There was no September monthly behavior monitoring flowsheet.</p> <p>"Resident Progress Notes," dated 10/3/11 at 4:50 p.m. Incident when resident pushed a 3 y/o boy. Doctor notified at 5:10 p.m., and order received to send resident to St. Joe for eval and treat.</p> <p>A "Resident Transfer Form," dated 10/3/11, indicated Resident #C was transferred to a local acute hospital emergency room. Diagnoses included: schizoid personality, hemiplegia,</p> | | | | | | |

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| | <p>cerebrovascular accident (stroke), anemia and congestive heart failure. The reason for transfer listed increased agitation with the resident pushing a 3 y/o child down. The additional pertinent information indicated the resident pushed a visitor's 3 year old child who was on the scale. The resident told the child to "get his little ... off there. The note further indicated the resident had impulsive behavior, some problems with temper and anger at times.</p> <p>October nursing assistant care records had no behaviors marked. October monthly behavior monitoring flowsheet had one incident of physical aggression and anger with others on 10/3.</p> <p>Interdisciplinary Discharge Summary, dated 10/3/11, indicated: discharged to generations, able to make needs known, alert and oriented x 3, ambulatory, needs assist with ADLs, abusive behaviors - sent to Generations for eval/treat, resident preferred to be alone listening to his Walkman or watching tv. Form was blank on some areas: personal belongings sent...vitals...labs...etc. Discharge summary was not necessary since resident went out on an emergency basis.</p> <p>The most recent inservice for behaviors, dated 8/1/11, listed the following: "...some common behaviors...physical</p> | | | | | | |

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| | <p>aggression...verbal aggression...exit seeking...resisting or refusing care...obsessive behavior...if behaviors are not reported and logged, it is very difficult to maintain them...the social worker must be notified in writing of new behaviors...behaviors must be logged on the behavior logs in the nurses station...."</p> <p>The current policy and procedure for "Resident Exhibiting Challenging Behaviors," dated 6/30/06 was provided by the Director of Nursing on 11/10/11 at 12:00 p.m. The policy listed the following: "...A resident exhibiting behavior symptom is intervened with measures that reduce and/or eliminate behavior episodes while protecting the resident and/or others from harm...record the behavior(s) exhibited, interventions tried but unsuccessful, and/or successful interventions used on behavior monitoring log or similar tracking device...update the resident's care plan, as needed...communicate resident behavior symptoms to appropriate disciplines...evaluate resident condition every shift for at least 72-hours or more frequently as determined by the interdisciplinary team...document sequence of events of resident's behavior in resident's medical record...details of the event...staff monitoring, if applicable...document behaviors and</p> | | | | | | |

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| | <p>interventions on behavior monitoring log or similar tracking device...."</p> <p>An interview was conducted with Social Services #2 on 11/10/11 at 12:20 p.m. During the interview, Social Service #2 indicated there was no follow up to a psychiatric visit requested upon discharge from a local psychiatric facility back in June for Resident #C. She further indicated there was no care plan for preference for male caregivers, she indicated he initially had a male caregiver before he changed rooms but it wasn't care planned.</p> <p>This Federal tag relates to Complaint IN00099184 and IN00099274.</p> <p>3.1-34(a)</p> | | | | | | |

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| F0279 SS=D | <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to update the care plan for resident's preference for male caregivers, behaviors of refusing to change clothes and take showers and provide additional interventions for behaviors for 1 of 3 residents reviewed for behaviors and care plans. [Resident #C]</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 11/9/11 at 10:00 a.m. The record indicated Resident #C's diagnoses included, but were not limited to, fractured femur (hip), cerebrovascular accident (stroke), chronic obstructive</p> | | | F0279 | <p>F 279</p> <p>I. Resident #C no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>II. All residents with behaviors have the potential to be affected, therefore, this plan of correction applies to all of those residents. The medical records of these residents have been reviewed to determine if behaviors have been</p> | | 12/10/2011 |

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| | <p>pulmonary disease, legal blindness, and schizoid personality.</p> <p>A "Nursing Assessment/Full," dated 1/25/11, indicated Resident #C was admitted to the facility on 1/25/11.</p> <p>"Resident Progress Notes," dated 1/26/11 at 8:00 p.m., indicated resident had some confusion, was yelling at staff to leave him alone and was non-compliant with personal alarm.</p> <p>"Resident Progress Notes," dated, 1/26/11 at 1:00 p.m., indicated Resident #C was easily agitated at staff and yells out and slaps at staff during care.</p> <p>Admission care plan for inappropriate behaviors, dated 1/27/11, indicated resident displays inappropriate behaviors as evident by yelling at staff, refusing care, and non-compliant with personal alarm.</p> <p>"Resident Progress Notes," dated 1/30/11 at 9:05 p.m., indicated Resident #C takes his nicotine patch off himself.</p> <p>"Resident Progress Notes," dated 2/7/11 at 4:15 p.m., resident removes personal alarm and hides pieces.</p> <p>March nursing assistant care record had</p> | | | <p>appropriately assessed, monitored, and documented with any identified concerns corrected. All resident records have been reviewed in an effort to ensure all recommended psychiatric follow-up has been done, and to ensure any residents requiring referral to PASRR for Level II completion have been referred accordingly. The care plans of all residents currently receiving psychotropic medications have been reviewed to ensure the same are addressed. The care plans of any resident who have voiced a preference for male versus female, or vice versa, caregivers have been reviewed to ensure the same is addressed.</p> <p>III. Nursing center staff have received in-service education relative to behavior management process, including but not limited to behavior assessment, monitoring,</p> | | | |

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| | <p>one behavior on the 9th (AM). PM shift had behaviors x2 on 3/1, 2, 3, 4, 5, 6, 7, 8, and one on the 9th and two on the 10th.</p> <p>"Resident Progress Notes," indicated on 4/13/11, resident displayed behaviors toward CNA per Anna in therapy. Resident agitated and threw water pitcher at CNA.</p> <p>Inappropriate behavior care plan, dated 1/27/11, had an updated behavior 4/14/11 but no new interventions.</p> <p>April monthly behavior monitoring flowsheet had verbal aggression on 4/19.</p> <p>May nursing assistant care record had 3 behaviors on the 2nd. May monthly behavior monitoring flowsheet had inappropriate gestures on 5/7 and 5/8; verbal aggression on 2nd and 8th. The monthly behavior summary/psychoactive GDR dated June which reviewed May behaviors had 2 incidents of verbal aggression and 1 of inappropriate gestures.</p> <p>"Resident Progress Notes," dated 6/2/11 at 6:30 p.m., indicated resident observed shoving a glass of milk towards a resident at his table because resident was tapping his cup at the table.</p> | | | <p>and documentation. Social Service staff and Licensed Nursing staff have received in-service education relative to the care plan process, including but not limited to inclusion of psychotropic medication use, compliance with recommended psychiatric follow-up, and any care preferences voiced by residents. A performance improvement tool has been developed to monitor compliance with behavior management process, as well as PASRR paperwork and required level II.</p> <p>A performance improvement tool has been developed to monitor compliance with addressing of psychotropic medications and resident care preferences on care plans. Executive Director, or designee, and Social Service staff, or designee, shall be responsible for completion of these PI tools daily, on scheduled days of work, for 30 days. Any identified concerns will be promptly addressed with</p> | | | |

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| | <p>"Resident Progress Notes," dated 6/2/11 at 7:30 p.m., resident witnessed walking past a peer and purposefully kicking peer.</p> <p>A new care plan listed resident kicking another resident 6/6/11. Talked about 15 minute checks.</p> <p>A "Resident Monitoring Tool," dated 6/8/11, indicated the resident threw a chair at a CNA and that the resident was put on 15 minute checks.</p> <p>A "Resident Transfer Form," dated 6/10/11, indicated Resident #C was being transferred to the psychiatric unit at a local hospital due to behavioral disturbance.</p> <p>Progress notes from local hospital, dated 6/15/11, indicated resident "remains schizoid...makes it clear though that he prefers male company to female...keeps to himself and continues to isolate with his headphones or by remaining in his room...."</p> <p>An "External Transfer Report," dated 6/17/11 from a local hospital, indicated Resident #C had been hospitalized from 6/10/11 through 6/17/11 and was being transferred back to the facility. The report indicated the resident was confused at times and was to follow up with psych</p> | | | | <p>responsible individual(s).</p> <p>IV. Social Service staff will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>Completion Date: 12.10.11</p> | | |

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| | <p>care in 4-6 weeks.</p> <p>Hospital discharge notes indicated the resident was returning to the facility with a new order for abilify (antipsychotic) 3mg every night at bedtime.</p> <p>June nursing assistant care records for AM listed behaviors x 2 on 6/1 and only 1 behavior on 6/2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 20. The June monthly behavior monitoring flowsheet had verbal aggression on the 19th and 20th; inappropriate gestures on 6/5 and throwing objects on 6/2. The July monthly behavior summary/psychoactive GDR review listed no behaviors for June.</p> <p>"Resident Progress Notes," dated 7/9/11, indicated resident confused and yelling at staff all shift.</p> <p>An "Intra-facility Transfer," dated 7/12/11, indicated Resident #C was moved from Room [room number documented] to Room [room number documented] for bed management.</p> <p>"Resident Progress Notes," dated 7/18/11 at 9:30 a.m., roommate reported writer turning off the air in their room and what the resident had said to the CNA.</p> <p>"Resident Progress Notes," dated 7/24/11</p> | | | | | | |

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| | <p>at 7:50 a.m., CNA instructed resident to change his clothes and resident stated "Go yourself."</p> <p>"Resident Progress Notes," dated 7/25/11 at 11:30 p.m., resident became upset in MDR this evening because a resident accidentally hit his food with her w/c pedal. Resident threw silverware on the ground and left MDR.</p> <p>July nursing assistant care record had no behaviors marked. The July monthly behavior monitoring flowsheet listed verbal aggression on 7/18 and 7/25.</p> <p>"Resident Progress Notes," 7:30 a.m., patient cursed at CNA for asking him to change out of dirty clothes.</p> <p>"Determining Cause of Disruptive Behavior," dated 8/18/11, indicated physically aggressive behavior. It indicated the resident was upset with the housekeeper who was temporarily moving his belongings from room to lounge while floor being torn up/replaced. The report indicated Resident #C hit the housekeeper on the arm. Possible trigger "...did not understand fully that his things were being temporarily moved, thought things were being taken...." See nurse's notes for further details.</p> | | | | | | |

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| | <p>August nursing assistant care records have no behaviors. Monthly behavior monitoring flowsheet for August had one inappropriate gesture on the 30th, and verbal aggression on the 3rd, 6th, 9th, 12th.</p> <p>Consultant pharmacist's medication regimen review, dated 8/28/-8/30/11, indicated labs were missing in the chart. A hand written note indicated the resident had refused and the orders were canceled.</p> <p>A care plan for risk for adverse effects related to use of psychotropic medication (abilify), dated 9/8/11 however abilify was started in June.</p> <p>A care plan for self care deficit (ADL), dated 9/8/11, did not list the resident prefers males, it did not list that resident had been refusing showers and changing clothes or other behaviors.</p> <p>September nursing assistant care record - 2 behaviors on night shift 9/1. There was no September monthly behavior monitoring flowsheet.</p> <p>"Resident Progress Notes," dated 10/3/11 at 4:50 p.m. Incident when resident pushed a 3 y/o boy. Doctor notified at 5:10 p.m., and order received to send resident to St. Joe for evaluation and</p> | | | | | | |

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| | <p>treatment.</p> <p>A "Resident Transfer Form," dated 10/3/11, indicated Resident #C was transferred to a local acute hospital emergency room. Diagnoses included: schizoid personality, hemiplegia, cerebrovascular accident (stroke), anemia and congestive heart failure. The reason for transfer listed increased agitation with the resident pushing a 3 y/o child down. The additional pertinent information indicated the resident pushed a visitor's 3 year old child who was on the scale. The resident told the child to "get his little ... off there. The note further indicated the resident had impulsive behavior, some problems with temper and anger at times.</p> <p>October nursing assistant care records had no behaviors marked. October monthly behavior monitoring flowsheet had one incident of physical aggression and anger with others on 10/3.</p> <p>Interdisciplinary Discharge Summary, dated 10/3/11, indicated: discharged to local hospital for abusive behaviors. Resident preferred to be alone, listen to his Walkman or watching television.</p> <p>The current policy and procedure for "Resident Exhibiting Challenging Behaviors," dated 6/30/06 was provided</p> | | | | | | |

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| | <p>by the Director of Nursing on 11/10/11 at 12:00 p.m. The policy listed the following: "...A resident exhibiting behavior symptom is intervened with measures that reduce and/or eliminate behavior episodes while protecting the resident and/or others from harm...record the behavior(s) exhibited, interventions tried but unsuccessful, and/or successful interventions used on behavior monitoring log or similar tracking device...update the resident's care plan, as needed...communicate resident behavior symptoms to appropriate disciplines...evaluate resident condition every shift for at least 72-hours or more frequently as determined by the interdisciplinary team...document sequence of events of resident's behavior in resident's medical record...details of the event...staff monitoring, if applicable...document behaviors and interventions on behavior monitoring log or similar tracking device...."</p> <p>The Health Facility Administrator, Director of Nursing (DON) and Social Services #2 and #3 were interviewed on 11/10/11 at 12:20 p.m. During the interview, no additional care plans were provided by the listed employees. The DON indicated the resident had a male caregiver at one time before he changed rooms but that it wasn't care planned.</p> | | | | | | |

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| | This Federal tag relates to Complaint IN00099184 and IN00099274. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2) | | | | | | |

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| F0285 SS=D | <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a</p> | | | | | | |

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| NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN46815 | | | |
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| | <p>person with a related condition as described in 42 CFR 1009.</p> <p>Based on record review and interview, the facility failed to notify Pre-admission Screening/Pre-admission Screening Resident Review (PASRR) of a change in condition and new diagnosis for 1 of 3 residents reviewed for PASRR services. [Resident #C]</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 11/9/11 at 10:00 a.m. The record indicated Resident #C's diagnoses included, but were not limited to, fractured femur (hip), cerebrovascular accident (stroke), chronic obstructive pulmonary disease, legal blindness, and schizoid personality.</p> <p>A "Pre-Admission Assessment Summary," Level 1, dated 1/24/11, indicated Resident #C did not have any behaviors or antipsychotic/antianxiety/antidepressant medications and was going to LTC for short term rehab.</p> <p>History and Physical from a local hospital, dated 6/10/11, indicated "...resident...of an extended care facility, who recently became increasingly agitated and combative...this patient has been an</p> | | F0285 | <p>F 285</p> <p>I. Resident #C no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>II. All residents with behaviors have the potential to be affected, therefore, this plan of correction applies to all of those residents. The medical records of these residents have been reviewed to determine if behaviors have been appropriately assessed, monitored, and documented with any identified concerns corrected. All resident records have been reviewed in an effort to ensure all recommended psychiatric follow-up has been done, and to ensure any residents requiring referral to PASRR for Level II completion have been referred accordingly. The</p> | | 12/10/2011 | |

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| | <p>extended care facility resident since he had a fractured hip in February 2011...."</p> <p>A "Resident Transfer Form," dated 6/10/11, indicated Resident #C was being transferred to the psychiatric unit at a local hospital due to behavioral disturbance.</p> <p>Progress notes from local hospital, dated 6/15/11, indicated resident "remains schizoid...makes it clear though that he prefers male company to female...keeps to himself and continues to isolate with his headphones or by remaining in his room...."</p> <p>An "External Transfer Report," dated 6/17/11 from a local hospital, indicated Resident #C had been hospitalized from 6/10/11 through 6/17/11 and was being transferred back to the facility. The report indicated the resident was confused at times and was to follow up with psych care in 4-6 weeks.</p> <p>A "Nursing Assessment/Full," dated 6/17/11, indicated Resident #C was admitted to the facility on 6/17/11 and indicated a new diagnosis of schizoid disorder. The form did not list that the resident was on the antipsychotic medication abilify. It again listed the resident as a non-smoker, that the resident</p> | | | <p>care plans of all residents currently receiving psychotropic medications have been reviewed to ensure the same are addressed.</p> <p>The care plans of any resident who have voiced a preference for male versus female, or vice versa, caregivers have been reviewed to ensure the same is addressed.</p> <p>III. Nursing center staff have received in-service education relative to behavior management process, including but not limited to behavior assessment, monitoring, and documentation. Social Service staff, Business Office Manager, and Admissions Coordinator have been in-serviced on PASRR process and requirements, including but not limited to the need for a Level II referral in the event of a behavioral condition change. Social Service staff and Licensed Nursing staff have</p> | | | |

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| | <p>was occasionally confused, and had no mental retardation or dementia.</p> <p>A "Doctor's Progress Notes," dated 6/20/11, indicated Resident #C was sent out to a local psychiatric unit due to increased combativeness, agitation with mental health history. Indicated the resident was on Ability (antipsychotic medication) for schizoid disorder.</p> <p>Social Services #2 was interviewed on 11/10/11 at 10:50 a.m. During the interview, Social Services #2 indicated PASRR was not notified of the need for a reassessment (Level 2).</p> <p>This Federal tag relates to Complaint IN00099184 and IN00099274.</p> <p>3.1-16(d) 3.1-16(d)(1) 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)</p> | | | <p>received in-service education relative to the care plan process, including but not limited to inclusion of psychotropic medication use, compliance with recommended psychiatric follow-up, and any care preferences voiced by residents.</p> <p>A performance improvement tool has been developed to monitor compliance with behavior management process, as well as PASRR paperwork and required level II.</p> <p>A performance improvement tool has been developed to monitor compliance with addressing of psychotropic medications and resident care preferences on care plans. Executive Director, or designee, and Social Service staff, or designee, shall be responsible for completion of these PI tools daily, on scheduled days of work, for 30 days. Any identified concerns will be promptly addressed with responsible individual(s).</p> | | | |

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| F0406 SS=D | <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to ensure a psychiatric appointment was scheduled and attended as requested after a local psychiatric hospital discharge for 1 of 3 residents reviewed for appointments. [Resident #C]</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 11/9/11 at 10:00 a.m. The record indicated Resident #C's diagnoses included, but were not limited to,</p> | | | F0406 | <p>IV. Social Service staff will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>Completion Date: 12.10.11</p> <p>F 406</p> <p>I. Resident #C no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>II. All residents with behaviors have the potential to be affected, therefore, this plan of correction applies to all of those residents. All resident records have been</p> | | 12/10/2011 |

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| | <p>fractured femur (hip), cerebrovascular accident (stroke), chronic obstructive pulmonary disease, legal blindness, and schizoid personality.</p> <p>History and Physical from a local hospital, dated 6/10/11, indicated "...resident...of an extended care facility, who recently became increasingly agitated and combative...this patient has been an extended care facility resident since he had a fractured hip in February 2011...."</p> <p>A "Resident Transfer Form," dated 6/10/11, indicated Resident #C was being transferred to the psychiatric unit at a local hospital due to behavioral disturbance.</p> <p>An "External Transfer Report," dated 6/17/11 from a local hospital, indicated Resident #C had been hospitalized from 6/10/11 through 6/17/11 and was being transferred back to the facility. The report indicated the resident was confused at times and was to follow up with psych care in 4-6 weeks. No follow up was done.</p> <p>An interview was conducted with Social Services #2 on 11/10/11 at 12:20 p.m. During the interview, Social Service #2 indicated there was no follow up to a psychiatric visit requested upon discharge</p> | | <p>reviewed in an effort to ensure all recommended psychiatric follow-up has been done, and to ensure any residents requiring referral to PASRR for Level II completion have been referred accordingly.</p> <p>III. Nursing center staff have received in-service education relative to behavior management process, including but not limited to behavior assessment, monitoring, and documentation. Social Service staff, Business Office Manager, and Admissions Coordinator have been in-serviced on PASRR process and requirements, including but not limited to the need for a Level II referral in the event of a behavioral condition change. Social Service staff and Licensed Nursing staff have received in-service education relative to the care plan process, including but not limited to inclusion of psychotropic medication use, compliance with recommended psychiatric</p> | | | | |

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| | <p>from a local psychiatric facility back in June for Resident #C.</p> <p>This Federal tag relates to Complaint IN00099184 and IN00099274.</p> <p>3.1-23(a) 3.1-23(a)(1) 3.1-23(a)(2)</p> | | | <p>follow-up, and any care preferences voiced by residents.</p> <p>A performance improvement tool has been developed to monitor compliance with behavior management process, as well as PASRR paperwork and required level II.</p> <p>A performance improvement tool has been developed to monitor compliance with addressing of psychotropic medications and resident care preferences on care plans. Executive Director, or designee, and Social Service staff, or designee, shall be responsible for completion of these PI tools daily, on scheduled days of work, for 30 days. Any identified concerns will be promptly addressed with responsible individual(s).</p> <p>IV. Social Service staff will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> | | | |

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